

Introduced by Senator SpeierFebruary 20, 2004

An act to amend Section 1366.35 of the Health and Safety Code, and to amend Section 10785 of the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 1630, as introduced, Speier. Health care.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the licensure and regulation of health insurers by the Department of Insurance. Existing law prohibits a health care service plan or health insurer from declining to offer coverage to or deny enrollment of a federally eligible defined individual, as defined.

This bill would make nonsubstantive changes to these provisions.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 1366.35 of the Health and Safety Code
2 is amended to read:
3 1366.35. (a) A health care service plan providing coverage
4 for hospital, medical, or surgical benefits under an individual
5 health care service plan contract may not, with respect to a
6 federally eligible defined individual desiring to enroll in
7 individual health insurance coverage, decline to offer coverage to,
8 or deny enrollment of, the individual or impose any preexisting
9 condition exclusion with respect to the coverage.



(b) For purposes of this section, “federally eligible defined individual” means an individual who, as of the date on which the individual seeks coverage under this section, meets all of the following conditions:

(1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002).

(2) Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage.

(3) Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud.

(4) If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.

(c) Every health care service plan shall comply with applicable federal statutes and regulations regarding the provision of coverage to federally eligible defined individuals, including any relevant application periods.

(d) A health care service plan shall offer the following health benefit plan contracts under this section that are designed for, made generally available to, are actively marketed to, and enroll, individuals: (1) either the two most popular products as defined in Section 300gg-41(c)(2) of Title 42 of the United States Code and Section 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2) the two most representative products as defined in Section 300gg-41(c)(3) of the United States Code and Section 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as determined by the plan in compliance with federal law. A health care service plan that offers only one health benefit plan contract to individuals, excluding health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this article if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this article.

(e) (1) In the case of a health care service plan that offers health insurance coverage in the individual market through a network plan, the plan may do both of the following:

1 (A) Limit the individuals who may be enrolled under that
2 coverage to those who live, reside, or work within the service area
3 for the network plan.

4 (B) Within the service area of the plan, deny coverage to
5 individuals if the plan has demonstrated to the director that the plan
6 will not have the capacity to deliver services adequately to
7 additional individual enrollees because of its obligations to
8 existing group contractholders and enrollees and individual
9 enrollees, and that the plan is applying this paragraph uniformly
10 to individuals without regard to any health status related factor of
11 the individuals and without regard to whether the individuals are
12 federally eligible defined individuals.

13 (2) A health care service plan, upon denying health insurance
14 coverage in any service area in accordance with subparagraph (B)
15 of paragraph (1), may not offer coverage in the individual market
16 within that service area for a period of 180 days after the coverage
17 is denied.

18 (f) (1) A health care service plan may deny health insurance
19 coverage in the individual market to a federally eligible defined
20 individual if the plan has demonstrated to the director both of the
21 following:

22 (A) The plan does not have the financial reserves necessary to
23 underwrite additional coverage.

24 (B) The plan is applying this subdivision uniformly to all
25 individuals in the individual market and without regard to any
26 health status-related factor of the individuals and without regard
27 to whether the individuals are federally eligible individuals.

28 (2) A health care service plan, upon denying individual health
29 insurance coverage in any service area in accordance with
30 paragraph (1), may not offer that coverage in the individual market
31 within that service area for a period of 180 days after the date the
32 coverage is denied or until the issuer has demonstrated to the
33 director that the plan has sufficient financial reserves to underwrite
34 additional coverage, whichever is later.

35 (g) The requirement pursuant to federal law to furnish a
36 certificate of creditable coverage shall apply to health insurance
37 coverage offered by a health care service plan in the individual
38 market in the same manner as it applies to a health care service plan
39 in connection with a group health benefit plan.

(h) A health care service plan shall compensate a life agent or fire and casualty broker-agent whose activities result in the enrollment of federally eligible defined individuals in the same manner and consistent with the renewal commission amounts as the plan compensates life agents or fire and casualty broker-agents for other enrollees who are not federally eligible defined individuals and who are purchasing the same individual health benefit plan contract.

(i) Every health care service plan shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the Health Insurance Portability and Accountability Act of 1996, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits in order to become a federally eligible defined individual.

(j) No health care service plan may request documentation as to whether or not a person is a federally eligible defined individual other than is permitted under applicable federal law or regulations.

(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.

(l) This section shall apply to health care service plan contracts offered, delivered, amended, or renewed on or after January 1, 2001.

SEC. 2. Section 10785 of the Insurance Code is amended to read:

10785. (a) A disability insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan as defined in subdivision (a) of Section 10198.6 may not, with respect to a federally eligible defined individual desiring to enroll in individual health insurance coverage, decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.

(b) For purposes of this section, “federally eligible defined individual” means an individual who, as of the date on which the individual seeks coverage under this section, meets all of the following conditions:

(1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal

1 employees, or a governmental plan or church plan as defined in the
2 federal Employee Retirement Income Security Act of 1974 (29
3 U.S.C. Sec. 1002).

4 (2) Is not eligible for coverage under a group health plan,
5 Medicare, or Medi-Cal, and does not have other health insurance
6 coverage.

7 (3) Was not terminated from his or her most recent creditable
8 coverage due to nonpayment of premiums or fraud.

9 (4) If offered continuation coverage under COBRA or
10 Cal-COBRA, has elected and exhausted that coverage.

11 (c) Every disability insurer that covers hospital, medical, or
12 surgical expenses shall comply with applicable federal statutes and
13 regulations regarding the provision of coverage to federally
14 eligible defined individuals, including any relevant application
15 periods.

16 (d) A disability insurer shall offer the following health benefit
17 plans under this section that are designed for, made generally
18 available to, are actively marketed to, and enroll, individuals:

19 (1) either the two most popular products as defined in Section
20 300gg-41(c)(2) of Title 42 of the United States Code and Section
21 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2)
22 the two most representative products as defined in Section
23 300gg-41(c)(3) of the United States Code and Section
24 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as
25 determined by the insurer in compliance with federal law. An
26 insurer that offers only one health benefit plan to individuals,
27 excluding health benefit plans offered to Medi-Cal or Medicare
28 beneficiaries, shall be deemed to be in compliance with this
29 chapter if it offers that health benefit plan contract to federally
30 eligible defined individuals in a manner consistent with this
31 chapter.

32 (e) (1) In the case of a disability insurer that offers health
33 benefit plans in the individual market through a network plan, the
34 insurer may do both of the following:

35 (A) Limit the individuals who may be enrolled under that
36 coverage to those who live, reside, or work within the service area
37 for the network plan.

38 (B) Within the service area covered by the health benefit plan,
39 deny coverage to individuals if the insurer has demonstrated to the
40 commissioner that the insured will not have the capacity to deliver

1 services adequately to additional individual insureds because of its
2 obligations to existing group policyholders, group contractholders
3 and insureds, and individual insureds, and that the insurer is
4 applying this paragraph uniformly to individuals without regard to
5 any health status-related factor of the individuals and without
6 regard to whether the individuals are federally eligible defined
7 individuals.

8 (2) A disability insurer, upon denying health insurance
9 coverage in any service area in accordance with subparagraph (B)
10 of paragraph (1), may not offer health benefit plans through a
11 network in the individual market within that service area for a
12 period of 180 days after the coverage is denied.

13 (f) (1) A disability insurer may deny health insurance
14 coverage in the individual market to a federally eligible defined
15 individual if the insurer has demonstrated to the commissioner
16 both of the following:

17 (A) The insurer does not have the financial reserves necessary
18 to underwrite additional coverage.

19 (B) The insurer is applying this subdivision uniformly to all
20 individuals in the individual market and without regard to any
21 health status-related factor of the individuals and without regard
22 to whether the individuals are federally eligible defined
23 individuals.

24 (2) A disability insurer, upon denying individual health
25 insurance coverage in any service area in accordance with
26 paragraph (1), may not offer that coverage in the individual market
27 within that service area for a period of 180 days after the date the
28 coverage is denied or until the insurer has demonstrated to the
29 commissioner that the insurer has sufficient financial reserves to
30 underwrite additional coverage, whichever is later.

31 (g) The requirement pursuant to federal law to furnish a
32 certificate of creditable coverage shall apply to health benefits
33 plans offered by a disability insurer in the individual market in the
34 same manner as it applies to an insurer in connection with a group
35 health benefit plan policy or group health benefit plan contract.

36 (h) A disability insurer shall compensate a life agent or fire and
37 casualty broker-agent whose activities result in the enrollment of
38 federally eligible defined individuals in the same manner and
39 consistent with the renewal commission amounts as the insurer
40 compensates life agents or fire and casualty broker-agents for



1 other enrollees who are not federally eligible defined individuals
2 and who are purchasing the same individual health benefit plan.

3 (i) Every disability insurer shall disclose as part of its COBRA
4 or Cal-COBRA disclosure and enrollment documents, an
5 explanation of the availability of guaranteed access to coverage
6 under the Health Insurance Portability and Accountability Act of
7 1996, including the necessity to enroll in and exhaust COBRA or
8 Cal-COBRA benefits in order to become a federally eligible
9 defined individual.

10 (j) No disability insurer may request documentation as to
11 whether ~~or not~~ a person is a federally eligible defined individual
12 other than is permitted under applicable federal law or regulations.

13 (k) This section shall not apply to coverage defined as excepted
14 benefits pursuant to Section 300gg(c) of Title 42 of the United
15 States Code.

16 (l) This section shall apply to policies or contracts offered,
17 delivered, amended, or renewed on or after January 1, 2001.

